



Your Child's Name		Nickname	
Today's Date		Birth Date	
Patient Account No.		Medical Alert	

- Yes No
- Your child's physician name _____ Phone _____
Address _____ City _____ State _____ Zip _____
 - Is your child under the care of a physician? Yes No
If yes, please describe: _____
 - Is your child taking any medications? (prescription or over-the-counter) Yes No
If yes, please describe: _____
 - Have you ever been told your child needs antibiotics or premeds before treatment? Yes No
 - Does your child have any allergic (or adverse) reaction to any medication or other substance? Yes No
If yes, please list: _____
 - Are your child's immunizations current? Yes No
- List any hospitalizations, surgeries, serious illnesses When?
- _____
- _____
- _____

7. Indicate which of the conditions your child has now or ever has had. Check "yes" or "no".

	Yes	No		Yes	No		Yes	No
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Latex sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Allergies or hives	<input type="checkbox"/>	<input type="checkbox"/>	Handicaps/disabilities	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Other?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list: _____					

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Patient/Guardian Signature _____ Date _____



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Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

Yes No

1. What is the reason for your visit today? _____

2. What was done at your child's last dental visit? _____

Date of last dental visit _____ Last dental cleaning _____ Last x-rays _____

Your child's previous dentist name _____ Phone _____

Address _____ City _____ State _____ Zip _____

How often does your child brush? _____ Floss? _____ Do you assist? _____

Is your child's water fluoridated?.....

Does your child take fluoride supplements?.....

3. Does your child have any dental problems now?.....

If yes, please describe: _____

4. Has your child had difficulty with previous dental visits?.....

If yes, please describe: _____

5. Has your child complained about dental problems?.....

If yes, please describe: _____

6. Has your child ever worn orthodontic appliances?.....

If yes, please describe: _____

7. Are your child's teeth sensitive to:

Hot or cold? Yes No | Sweets? Yes No | Biting or Chewing? Yes No

8. Does your child engage in any of the following? Check "yes" or "no".

	Yes	No		Yes	No
Sucking thumb or fingers?	<input type="checkbox"/>	<input type="checkbox"/>	Chewing or biting fingernails?	<input type="checkbox"/>	<input type="checkbox"/>
Biting or sucking lips or cheeks?	<input type="checkbox"/>	<input type="checkbox"/>	Chewing hard objects (e.g., pencils)?	<input type="checkbox"/>	<input type="checkbox"/>
Grinding teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Clenching jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Mouth breathing?	<input type="checkbox"/>	<input type="checkbox"/>	Nursing bottle or pacifier habits?	<input type="checkbox"/>	<input type="checkbox"/>

10. Do your child's gums bleed or hurt?.....

11. Does your child have any pain or tenderness in the jaw joint, ear side of face?.....

12. Do you have any special concerns about your child's dental health?.....

If yes, please describe: _____
